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Letters to the Journal

Letters are welcomed and will be published as space permits. Like other material submitted for publication, they should be typewritten, double-spaced, should be of reasonable length, and will be subject to the usual editing. The accuracy of statements of fact contained in these letters is the responsibility of the correspondent.
Views expressed in Letters to the Journal are those of the writers concerned and are NOT to be interpreted as the opinions of The Canadian Medical Association or of the editors.

TREATMENT OF CHRONIC SUPPURATIVE OTITIS MEDIA

To the Editor:

I would like to add an otologist's comment to Dr. William R. Galloway's interesting letter published in the issue of May 14 (*Canad. Med. Ass. J.*, 94: 1062, 1966).

Dr. Galloway recommends the use of Aerosol Polybactrin Powder for the treatment of chronic suppurative otitis media. I feel that attention should be drawn to the fact that chronic suppurative otitis media may be a sign of serious underlying disease and quote from an article by Colin M. Johnston (*Brit. Med. J.*, 1: 1091 [April 30], 1966), "Diagnosis and Treatment of Discharging Ears": "A major and important cause of chronic otitis media is cholesteatoma . . . the onset is insidious and the progress silent except for a persistent discharge . . . its importance lies in the risk of serious or possibly fatal complications from erosion of bone". He goes on to recommend "unless expert opinion has pronounced the ear to be 'safe' persistence of the discharge in the middle ear however scanty must be regarded as a potential source of danger. The absence of pain or a complaint of deafness is of no significance in this respect. . . ."

I am sure that Dr. Galloway is aware of these possibilities and I forward these comments for other practitioners less acquainted with the potential dangers of this condition.

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EARLY DEVELOPMENT OF LANGUAGE IN DEAF CHILDREN

To the Editor:

I note in the Provincial News section of the June 4 issue (*Canad. Med. Ass. J.*, 94: adv. p. 6, 1966) a reference to a project for the Early Development of Language in Deaf Children which is being launched by McGill University and the Royal Victoria Hospital. It is stated that "the type of program planned will be unique not only in Montreal, but in Canada. At present, very little work with such young children is being attempted anywhere."

We in the far west are delighted that at long last such a project should be undertaken even if it is on such an extremely modest scale. However, for the sake of accuracy it should be pointed out that similar work was first started at the Health Centre for Children in Vancouver, British Columbia, in 1948. Further impetus was given to this program in 1953 when the late Dr. Edith Whetnall from London, England, visited Vancouver, and as a result of her visit a pilot project was started and case finding was instituted through the public health personnel for early diagnosis. In 1958 Dr. David Kendall joined in this work, and preschool classes were formed at Sunny Hill Hospital for Children in Vancouver in 1963. The first of these classes will graduate this year into the regular school system. The budget for the assessment and training of these children in the preschool stage is approximately $100,000.

Perhaps those interested might like to consult a paper by Drs. Geoffrey Robinson, David Kendall and Kenneth Cambon published in *Pediatrics*, Vol. 32, p. 103, July 1963, entitled "Hearing Loss in Infants and Preschool Children".

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CHEST SURVEYS AND LUNG CANCER

To the Editor:

When radiographs of the chest taken in the year 1962-1963 were reviewed by the Tuberculosis Prevention Branch of the Department of Health for Ontario, and by the Gage Institute of the National Sanitarium Association, it was found that cancer of the lung had been recorded as a possible or probable diagnosis several hundred times.

A survey of 337 such cases was carried out by the Medical Advisory Committee of the Ontario Division of the Canadian Cancer Society, with the co-operation of the two organizations concerned (the Department of Health, Province of Ontario, and the National Sanitarium Association). Questionnaires were sent to the attending physicians and replies were received from 267, approximately 80%.

In 23 (8.6%) of the 267 replies, the attending physician reported that he did not know the current health of the patient after the survey film was reported, because the patient either had not returned to his office or had been referred by him to another doctor.

TABLE I.—QUESTIONNAIRE SURVEY OF 337 CASES IN WHICH LUNG CANCER WAS SUSPECTED FROM CHEST FILMS

Questionnaires sent to doctors	337
Definite diagnoses made	199
Individuals proved to have lung cancer	94 (47.3%)

The survey showed that, of the 337, a definite diagnosis had been made in 199, and 94 of these patients (47.3%) had lung cancer (Table I).

The age and sex of 76 of the 94 lung cancer patients are shown in Table II.

TABLE II.—AGE AND SEX OF 76 LUNG CANCER PATIENTS

Age	*Male*	*Female*
30-49	10	5
50-59	19	4
60-69	21	2
70 and over	13	2

In the past, some of the value of survey programs has been lost because the patient, and perhaps occasionally the doctor, delayed in following the matter to its logical conclusion, once the abnormality in the chest radiograph had been recognized. Since in invasive cancer there is little time to be lost before the lesion reaches a point where it is incurable, prompt action is important.

In view of these findings, the Department of Health for the Province of Ontario and the Chest Clinic of the Gage Institute (Toronto) have changed their notification procedures so that, in addition to the usual notice to the doctor indicating suspicion of new growth, an additional notice is now sent to him after an interval of about one month.

Considering the great importance of early diagnosis and treatment, the high degree of accuracy in x-ray diagnosis, and the fact that nearly 9% of the persons surveyed during this period (1962-1963) did not get or keep in touch with their doctors, every effort should be made to see that the information gained during these surveys is acted upon promptly. If this is to be done, the survey authorities, the attending physician and the individual patient must each do his part.

A further study is being planned to determine to what extent sputum cytology may aid in establishing the correct diagnosis in cases in which radiographs suggest cancer of the lung.

Grateful acknowledgment is made of the advice and assistance received from Drs. H. T. McClintock, W. D. S. Jamieson, W. G. Cosbie and N. C. Delarue during this analysis.

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RESIDUAL FLUID IN THE KNEE

To the Editor:

I would like to describe a method of demonstrating a minimal amount of fluid in the knee joint when patellar riding is absent. I have found this method useful although I have not seen it described in textbooks.

The routine examination of the knee joint may be negative, or there may be a slight filling of the dimples astride the patella. In either case, if retropatellar fluid is present it may be demonstrated in the supine patient by slight pressure with the "palm" of the fingers applied over the dimple area on either side of the patella (without touching the patella). In this way the fluid may be moved from side to side and it can be observed to fill the dimple area on the side to which the fluid is moved. The change is visible; that is, it is more subtle than palpable fluctuation. It is best to use two or three fingers of each hand to mobilize the fluid.

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PAINLESS INJECTIONS

To the Editor:

I have had experience with the Dermo-jet, described by Drs. M. Boisvert and H. Drolet (*Canad. Med. Ass. J.*, 94: 1280, 1966), and a modification of it produced by the Micro-Biological Research Establishment, Porton, England.

The modification consists of a foot-operated needleless injector capable of carrying out intradermal and subcutaneous injections of large numbers of people. I have used it with TABT and cholera vaccines, inoculating up to 500 soldiers in a 90-minute period. It has also been used in dermatological practice for topical infiltration of various medicaments including steroids.

A theoretical possibility is that these machines may cause an implantation dermoid. Experiments with radiopaque solutions have indicated that this could be caused by the extreme pressure with which the jet is forced into the skin. Operators should always be warned of the danger of firing "practice shots" in the presence of bystanders, as such procedures could cause severe eye damage.

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To the Editor:

We have read with interest the letter to the Journal in the June 11 issue on the use of the Dermo-jet (*Canad. Med. Ass. J.*, 94: 1280, 1966).

We would appreciate it if you would inform the readers of the Journal that the name Dermo-jet has been changed to PANJET, and that we have been appointed the Canadian distributors for this apparatus.

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CUTANEOUS PRECANCERS, CANCERS AND PSEUDOCANCERS

To the Editor:

Readers of the Journal may be interested in a brief account of a symposium on "Selected Aspects of Cutaneous Precancers, Cancers and Pseudocancers" which was held at New York Medical Center from April 27 to 29, 1966. The chairman was Dr. Rudolph L. Baer. There were approximately 150 registrants and participants.

There were six sessions, each lasting a full morning or afternoon. The subjects covered were carcinogenesis, ultraviolet carcinogenesis, precancers and carcinoma *in situ*, basal cell epitheliomas, management of skin cancers, and pseudocancers.

Dr. Frederick Urbach of Philadelphia reported on his studies of measurement of ultraviolet light on manikins exposed to sunlight under various conditions. He pointed out that considerable ultraviolet light is received even on a cloudy day and that to avoid ultraviolet light one had to stay indoors between 10:00 a.m. and 2:00 p.m. During these times big hats and sun screen creams were only of limited value. He also